Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #:	M4-09-A174-01
	DWC Claim #:	
	Injured Employee:	
	Date of Injury:	
Respondent Name and Box #: ZURICH AMERICAN INSURANCE CO REP. BOX #: 19	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as listed on the Table of Disputed Services: "Medications."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $722.76

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…Request is the injured worker. He has requested reimbursement for prescription medications with services dates 3/28/2006, 5/1/2006, 12/15/2006, and 1/12/2007. Requestor's DWC-60 is date stamped as received by the Division on July 23, 2009. The request is not timely as to each date of service. Pursuant to 28 TAC 133.307(c)(1)(A), a request for dispute resolution of medical fee dispute must be filed within one year of the service date…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
03/28/06 – 01/12/07	Out of Pocket Expenses – Prescription Medications	1 – 2	$0.00
Total:			$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and 28 Texas Administrative Code (TAC) Section 134.504, titled *Pharmaceutical Expenses Incurred by the Injured Employee,* effective on or after March 14, 2004, set out the reimbursement guidelines.

1. The request for medical fee dispute resolution was filed on July 23, 2009 and that date is after the one-year period of time allowed per Rule 133.307, for filing the request for all services.
2. Therefore, in accordance with 28 TAC Section 133.307(e)(3)(E) the request for medical fee dispute resolution is untimely and reimbursement cannot be recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section 413.0311
28 Texas Administrative Code Section. 134.1, 134.504, 133.307
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Auditor III Medical Fee Dispute Resolution	August 17, 2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.